Welcome to Will’s Way:

We want to thank you for choosing Will’s Way to help meet the needs of your family. We understand that choosing psychological services and mental health agencies can be stressful and time consuming so we thank you for selecting us. *Please review the enclosed documents carefully.*

* Complete the **New Intake Form** and return so we can schedule your first appointment. This form includes important questions about your child’s developmental, medical, and school histories and is vital to helping us provide the most appropriate treatment or service.
* Return **Custody Agreement**, if applicable, with New Intake Form.
  + If you are divorced or have a legal custody agreement, you MUST send the signed custody papers with this packet prior to scheduling your first appointment.
  + We will not schedule an appointment for you or your child until this paperwork is received in our office.
  + A legal guardian must be present at the initial appointment to give written consent for services. Step-parents, aunts, grandparents, or other caregivers without legal guardianship will NOT be allowed to sign consent for services.

Forms can be emailed to [info@willswaybehavioral.com](mailto:info@willswaybehavioral.com), faxed to 866-625-0559 or mailed to

32 Millbranch Road, Ste. 40

Hattiesburg, MS 39402

**Please provide the following PRIOR to your first appointment**:

* Insurance Card
* Previous Evaluations
* Previous Diagnoses
* List of any medications, including vitamins, herbs, and over-the-counter medicines your child is taking.

**Please provide the following to your first appointment**:

* Driver’s License
* List of all the changes that you and others have observed in your child’s behavior.
* Notes from other adults and caregivers, such as baby sitters, relatives, and teachers.
* Individual Education Plan, if applicable

**If for any reason you cannot make your first appointment, please provide 24 hours’ notice. Families missing or failing to cancel appointments within time limits, will be required to provide a credit or debit card number prior to scheduling subsequent appointments.**

For families seeking **evaluations**, please be aware that half of the estimated total cost may be due at your first appointment. Office staff will inform you of this estimate prior to your appointment.

We look forward to meeting you and your child and working closely with your family!

Sincerely,

Kimberly D. Bellipanni, Ph.D. , BCBA-D Dannell S. Roberts, Ph.D., BCBA-D

Clinical Director Program Director

School Psychologist/Behavior Analyst Licensed Psychologist/Behavior Analyst

Will’s Way, LLC Will’s Way, LLC

**POLICIES AND PROCEDURES**

**Confidentiality**

Your family’s privacy is very important to us and we encourage you to review our *Notice of Privacy Policy at your first appointment* for important details regarding our policies for maintaining privacy and confidentiality. Please note, that we will only contact you through means you specifically authorize in the intake paperwork. An *Authorization for Release of Information* form must be completed before we will discuss your child or your case with any other persons or agencies.

**Appointments**

Our office is open Monday through Thursday from 8:30 am until 5:00pm and on Friday from 8:30 am until 2:00pm. If you need to cancel a scheduled appointment, please call us immediately. Families missing or failing to cancel appointments within time limits will be required to provide a credit or debit card number prior to scheduling subsequent appointments. Appointments not cancelled with 24 hour notice will be subject to a $50.00 fee and will be processed on the given credit/debit card. If you arrive more than 15 minutes late for your appointment, we will make every effort to see you. However, please be aware that if we are not able to see you, you will be charged a $50.00 fee.

**Therapy Sessions**

*Therapy sessions are charged and billed in 50 minute increments.*

We do not have adequate space to accommodate large groups during therapy sessions. Please refrain from bringing other children or family members (e.g., friends, siblings) unless you have discussed this with us in advance.

**Fees**

We will provide you with the service fees associated with any type of therapy or assessment you are seeking prior to service delivery.

**Legal Proceedings**

Fees for legal proceedings (custody evaluations, depositions, testimonies, attorney meetings) are self-pay only. It is not considered therapy and will not be billed to your insurance.

**Payment**

Payment is expected at the time services are rendered. In cases where insurance companies are billed for services, please understand that you are ultimately responsible for the payment of services in the event that your insurance carrier denies payment or does not remit payment to us within 45 days. There will be a $30.00 fee for any returned checks.

**Health Insurance**

We currently participate with certain insurance companies, but not all. If you want to know prior to an appointment whether we have a relationship with your insurance company, please contact us at 601-255-5264.

**Legal Custody**

It is necessary for our office to maintain a copy of all legal custody papers. Appointments will not be scheduled until our office receives a copy of all custody papers. A legal guardian must be present at the initial appointment to give written consent for services. Step-parents, aunts, grandparents, or other caregivers without legal guardianship will NOT be allowed to sign consent for services.

**Emergencies**

In the event of a medical emergency or an immediate threat of harm, please call 911.

**Termination of Services**

Sometimes it is necessary to terminate services when continued participation is deemed as a potential detriment to the child or their family. In the event of such termination, we will do our best to provide you with alternatives for service delivery in the area. Additionally, in the event that you become delinquent in your financial obligations and allow your account to remain past due for more than 60 days, services will be suspended until payment is received.

**NEW INTAKE FORM**

Date Completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth (DOB) \_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST \_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell 1 & Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell 2 & Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Language Spoken in the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Service you are seeking:**

**Evaluation**  \_\_\_\_Yes \_\_\_\_No **Treatment/Therapy** \_\_\_\_ Yes \_\_\_\_No

Are you looking for an initial diagnosis or reevaluation/clarification of a diagnosis? If you are, mark evaluation.

*Are you looking for regularly occurring therapy appointments? If you are, mark therapy.*

*If you are looking for an evaluation first, to be followed by therapy, mark both.*

*If you are unsure what you are looking for, please call our office and our staff will be happy to help you.*

If Evaluation, what are you concerned about:\_\_\_\_ Autism Spectrum \_\_\_\_ADHD \_\_\_\_Learning Assessment

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check your preferred method of contact for Appointment Reminders and Other Contact:

Home Phone: \_\_\_\_\_ Cell 1: \_\_\_\_\_\_\_\_ Cell 2: \_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check** your preferred method of contact for Appointment Reminders and Other Contact:

Home Phone: \_\_\_\_\_ Cell 1: \_\_\_\_\_\_\_\_ Cell 2: \_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Relevant Caregivers:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibling Names/Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe living arrangements and visitation, if the child is not living full time with both biological parents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who has legal custody of the child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the parents are separated or divorced, is the other parent aware that you are seeking psychological services for your child? Yes No

**\*\*You must include the legal custody papers with this packet. \*\***

**CHILD’S DEVELOPMENTAL HISTORY**

Mother’s age at delivery\_\_\_\_\_\_ Father’s age at delivery \_\_\_\_\_\_\_

Approximate weight at birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Months/Weeks Carried \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any complications during pregnancy or birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Developmental Milestones. Please approximate the age (in months) your child did the following:*

\_\_\_\_\_\_ Walked independently \_\_\_\_\_\_\_\_ Said first word \_\_\_\_\_\_\_\_ Toilet trained

Did your child have any delays in their milestones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***CHILD’S HEALTH INFORMATION***

Pediatrician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any previous or existing medical or developmental conditions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name of Medication Frequency/Dose Prescribed For By Whom

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***CHILD’S SCHOOL AND EDUCATIONAL INFORMATION***

School History or Problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is your child in special education classes? Yes No If yes, describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***SOCIAL AND EMOTIONAL INFORMATION***

If applicable, describe any traumatic events your child has ever experienced (e.g., accidents, home fires, close relative or friend’s death) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If applicable, describe any history of physical or sexual abuse, family violence or neglect

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***SERVICE PROVIDER INFORMATION***

Please list all therapy (OT, PT, Speech) your child is receiving or has received starting with current:

Agency/ Therapist Name Type of Therapy Dates of Service Hours/week

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***PRESENTING CONCERNS***

Please describe why you are seeking services at this time. Please include past or present circumstances that could be contributing to the problem and when the problem began.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your expectations or your goals from services at our clinic?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How did you hear about us? \_\_\_\_Friend/Relative \_\_\_\_ Website \_\_\_\_Magazine \_\_\_Physician \_\_\_\_Other

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Insurance Information Form**

**\*\*Please include a copy of front and back of Client’s Insurance Card\*\***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Client Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Last Name | | | | | | First Name | | | | | | | MI | | | | | DOB | | | | | | Sex:  M F | | | | | | SS# | | | | | | |
| Address Apt# | | | | | | | | | | | | | | | | | City | | | | | | | | | | | State | | | | | Zip | | | |
| Mother’s Name (If minor) | | | | | | | | | | | | | | | | Father’s Name (If minor) | | | | | | | | | | | | | | | | | | | | |
| Home Phone | | | | | Mobile Phone | | | | | | | | | Work Phone | | | | | | | | Email Address | | | | | | | | | | | | | | |
| Emergency Contact Name | | | | | | | Emergency Contact Address | | | | | | | | | | | City | | | | | | State | | | Zip | | | | | Relationship | | | | |
| Emergency Contact Phone  Home | | | | | | | | | | | | Mobile | | | | | | | | | | | | | Work | | | | | | | | | | | |
| \*\*Insurance Information\*\*  **\*\*Please include a copy of front and back of Client’s Insurance Card\*\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary Insurance Company** | | | | | **Policy/Sponsor Number** | | | | | | | **Group Number** | | | | | | | | | **Effective Date** | | | | | | | | **Employer** | | | | | | | |
| **Insured’s Name** | | | **Insured DOB** | | | | | | | **Insured SSN#** | | | | | **Insured’s Address** | | | | | | | | | | | **City** | | | | | | | | **State** | **Zip** | |
| **Secondary Insurance** | | | | | **Policy/Sponsor Number** | | | | | | | **Group Number** | | | | | | | | | **Effective Date** | | | | | | | | **Employer** | | | | | | | |
| **Insured’s Name** | | | **Insured DOB** | | | | | | | **Insured SSN#** | | | | | **Insured’s Address** | | | | | | | | | | | **City** | | | | | | | | **State** | **Zip** | |
| Responsible Party Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person Responsible for Payment | | | | | | | | | Responsible Party Address | | | | | | | | | | | | City | | | | | | | | | State | | | | Zip | | |
| Home Phone | | | | Mobile Phone | | | | | | | | | | Work Phone | | | | | | | | | Email Address | | | | | | | | | | | | | |
| Responsible Party Employer | | | | | | | | Employer Address | | | | | | | | | | | City, State, Zip | | | | | | | | | | | | Telephone | | | | | |
|  | Assignments of Benefits | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my insurance be paid directly to the Provider. I also authorize the Provider to release my billing service and insurance company any and all information necessary for the processing of insurance claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient/Legal Guardian Signature | | | | | | | | | | | | | | | | | | | | | Date | | | | | | | | | | | | | | | |
| Patient/Legal Guardian Print Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Office Use Only | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Diagnostic Code | | 1. | | | | 2. | | | | | 3. | | | | 4. | | | | |  | | | | | | | | | | | | | | | | |